DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

NOV 13 2001

CIN: A-04-01-01005

Mr. John Hogan
Executive Director
Capital Health Plan
2140 Centerville Place
Tallahassee, Florida 32308

Dear Mr. Hogan:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' report entitled *Review of Duplicate Medicare Fee-For-Service Payments at Capital Health Plan*. A copy of this report will be forwarded to the action official noted below for his review and any action necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 United States Code 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 Code of Federal Regulations Part 5.) As such, within 10 business days after this final report is issued, it will be posted on the World Wide Web at http://www.hhs.gov/progorg/oig.

To facilitate identification, please refer to Common Identification Number (CIN) A-04-01-01005 in all correspondence relating to this report. If you have any questions, please call me or Andrew Funtal of my staff, at (404) 562-7800.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures – as stated

Direct Reply to HHS Action Official:
Mark Alark, Chief
Managed Care Audit Branch

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF DUPLICATE MEDICARE FEE-FOR-SERVICE PAYMENTS AT CAPITAL HEALTH PLAN

JANET REHNQUIST
Inspector General

NOVEMBER 2001
A-04-01-01005

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Mr. John Hogan
Executive Director
Capital Health Plan
2140 Centerville Place
Tallahassee, FL 32308

Dear Mr. Hogan:

This final report provides you with the results of our Review of Duplicate Medicare Fee-For-Service Payments at Capital Health Plan (CHP). Our review identified payments made to providers under Medicare's fee-for-service payment method (Medicare FFS) that duplicated payments made to CHP for the same services in Calendar Year 1999.

EXECUTIVE SUMMARY

The objective of this audit was to determine whether services that were claimed on CHP's 1999 Medicare cost report, and reimbursed by Medicare, were also billed to Medicare directly by providers and paid for under Medicare FFS, resulting in a duplicate payment for the same services.

Our review indicated that Medicare FFS made $30,283 in erroneous payments by paying for services that were both claimed on CHP's 1999 cost report and also billed directly to Medicare. Because Medicare paid physicians directly for these services, and reimbursed CHP for its expenses related to paying for the services, Medicare has paid twice for the same services.

These overpayments occurred because CHP did not have an adequate mechanism in place to prevent duplicate payments and because the billing staffs of the physicians servicing CHP's enrollees were inadequately trained in the appropriate billing process.

We recommend that CHP refund the $30,283 in overpayments made on behalf of CHP enrollees. Specifically, we recommend that CHP file an amended cost report that:

- Refunds the $23,573 in estimated duplicate payments identified in this audit;
- Records as credits, the $6,710 in duplicate payments that were made to physicians affiliated with and employed by CHP.

In addition, we recommend that CHP take steps to prevent duplicate payments from recurring in the future.

The CHP concurs with the OIG's recommendations and will contact Centers for Medicare and Medicaid Services (CMS)[1] to further discuss these items. The full text of CHP's response is attached to this report as APPENDIX C.

BACKGROUND

Capital Group Health Services of Florida, Inc. (d/b/a Capital Health Plan or CHP) is a federally qualified and State licensed HMO that provides health care services, primarily on a prepaid basis, to subscribers in the Tallahassee, Florida area. The CHP was organized and incorporated under the laws of the State of Florida on June 26, 1978. The CHP became federally qualified as an HMO on June 1, 1982, and has been affiliated with Blue Cross and Blue Shield of Florida, Inc. (BCBSF) since 1982.

The CHP contracts with various healthcare providers for the provision of certain medical services to its members, and compensates them on a capitation basis. The CHP has also entered into contractual agreements with various hospitals to provide hospital services to CHP's subscribers. In addition, CHP has entered into contractual arrangements with certain physicians to provide laboratory and specialized services.

The CHP's total revenues for 1998 and 1999 were $148,382,541 and $185,774,070, respectively. The CHP reported a net loss of $7,471,753 and net income of $1,672,871, respectively. The State of Florida is CHP's single largest customer, pursuant to a contract for health care services for State employees that lasts through 2004. State employee insurance represented approximately 38% and 39% of CHP's business in 1998 and 1999, respectively. By comparison, Medicare represented approximately 4.33% and 3.58% of its business.

The CHP has entered into a contract with CMS to provide benefits to Medicare beneficiaries. The CHP provides a convenient method of filing claims if using plan providers while still taking advantage of Medicare benefits and without having to pay deductibles. Instead of reimbursing medical expenses, CHP generally provides services directly to its members. To enroll in CHP as a Medicare member an individual must:

- be eligible for, or participate in, either Medicare Parts A and B, or Part B only;
- live in CHP's service area *Leon*, *Gadsden*, *Jefferson*, or *Wakulla* Counties;
- not have End Stage Renal Disease or have not had a kidney transplant in the past 36 months; and

[1] Prior to June 2001 the Centers for Medicare and Medicaid Services was known as the Health Care Financing Administration (HCFA). References to CMS should be construed as referring to HCFA where appropriate.

- have not elected to utilize the Medicare hospice benefit.

Additionally, one cannot be denied membership based on health, since the plan has no pre-existing condition clause.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of this audit was to determine whether services that were claimed on CHP's 1999 Medicare cost report, and reimbursed by Medicare, were also billed to Medicare directly by providers and paid for under Medicare FFS, resulting in a duplicate payment for the same services.

Scope

Our review determined the number and dollar amount of duplicate payments made to providers through Medicare FFS for services also claimed on CHP's annual cost report. The payments we reviewed were for services claimed as costs on CHP's Medicare cost report for calendar year (CY) 1999.

Methodology

Region IV's Advanced Audit Techniques Staff (AATS) downloaded an initial database of Medicare fee-for-service paid claims for all CHP beneficiaries during CY 1999. We then obtained a listing from CHP of all patient visits for which Medicare reimbursed costs based on CHP's Medicare Cost Report for CY 1999 and compared the two files to generate a listing of payments for beneficiaries with the same Health Insurance Claim Numbers (HICNs), dates of service, and similar types of procedures. This database match was based on line items, or the individual CMS Common Procedure Coding System (HCPCS) code(s) for each claim or encounter. For purposes of our review, we found it necessary to divide the payments into two categories based on the two separate methods used by CHP to track costs – claims and encounters.

As it pertains to the Medicare cost report at CHP, a claim is a payment made to non-capitated providers, whether they are CHP contractual providers or not. It is not a prepaid amount for services, but rather is paid on a per-service rendered basis. Thus the "claim" form on which the provider lists services performed, established one of the two bases for CHP's cost accumulation that later is reported to CMS via the annual cost report. Each of these claims is composed of line items that relate to each medical procedure performed during a visit. We selected a random sample from these line item matches (See APPENDIX A for details) and requested additional documentation to allow us to determine if the matches represented duplicate payments. We then projected the percent and dollar amount of line items that were in error to the universe (See APPENDIX B for details).

The second method of cost accumulation used by CHP is referred to as "encounters". An encounter is a service rendered by a salaried employee or a capitated provider, which is prepaid for the services performed. Furthermore, an encounter is a visit to a PCP (primary care physician) even though the provider may only be an affiliate of CHP (not employed, but signed a contract to provide services). The capitated providers are *prepaid* for services provided on a contractual fee schedule. The CHP uses an in-house "encounters" tracking system to accumulate costs associated with each encounter. There were significantly fewer *encounters* line items than *claims* line items among the potential duplicate payments, so we reviewed each encounter individually.

We conducted our audit in accordance with generally accepted government auditing standards. Fieldwork was performed at the offices of CHP in Tallahassee, Florida and at the Health and Human Services/Office of Inspector General/Office of Audit Services offices in Atlanta, Georgia and Tallahassee, Florida from January 2001 through June 2001.

DETAILED RESULTS OF REVIEW

Our review indicated that the Medicare program paid $30,283 in duplicate payments for CHP enrollees for CY 1999. Because Medicare paid physicians directly for these services, and also reimbursed CHP through its annual cost report for these same services, Medicare has paid twice. These overpayments are discussed in detail below. While the criteria for determining whether duplication occurred is the same for both line items relating to *claims* and *encounters*, our results with respect to each type of payment are discussed separately.

Criteria

The 42 CFR 417.532 contains the Federal regulations relating to Medicare payments made to cost-based Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs).. The 42 CFR 417.532(e)(1) through (4) requires HMOs and CMPs that elect to pay providers directly for Medicare services to:

(1) Determine the eligibility of its Medicare enrollees to receive covered services through the HMO or CMP;

(2) Make proper coverage decisions and appropriate payments…for the services furnished to its Medicare enrollees;

(3) Ensure that providers maintain and furnish appropriate documentation of physician certification and recertification, to the extent required under subpart B of part 424 of this chapter; and

(4) Carry out any other procedures required by the Health Care Financing Administration (HCFA).

In part, the other procedures required by HCFA are specified in the HMO Manual (CMS Publication 75). Section 6105 of the HMO Manual is entitled DUPLICATE PAYMENT DETECTION FOR COST CONTRACTING HMO/CMP and states:

> Several entities may have jurisdiction over the processing and payment of Part B bills for your members. This could result in duplicate payments to either the physician, supplier, or to the enrollee. It is incumbent upon you to establish a system to preclude or detect duplicate payments.

Section 6105 then describes some specific procedures to be utilized in a system to preclude or detect duplicate payments.

> Regardless of the claims option selected, process all non-provider Part B bills, with some exceptions (See §§6101 and 6103.) If a physician/supplier submits a HCFA-1500 for payment, be sure:
>
> 1. The bill was not previously paid; and
>
> 2. The bill was not for services restricted as defined in §§6101 and 6103.[2]
>
> After you receive paid claim information (denial or an [Explanation of Medicare Benefits] EOMB from the carrier), perform several duplicate check functions. If you have not previously paid the claim, file a copy of claims information in the beneficiary's history file. If your duplicate check reveals you have already paid for the service(s):
>
> 1. Contact the physician/supplier or enrollee to retrieve the overpayment;
>
> 2. Record any collections as credits on the cost report;
>
> 3. Notify HCFA of unresolved overpayment situations; and
>
> 4. Do not return payment to carrier

Line Items Relating to Claims

Due to the number of *claims* line items that could have potentially resulted in duplicate payments, we selected a random sample of line items relating to the claims match database for detailed analysis. We projected the errors identified in the sample to the universe of line items.

[2] Additional guidance on Non-Provider Part B services is presented in Section 6101.2 of the HMO Manual. Section 6103 addresses special procedures relating to outpatient blood, outpatient psychiatric care, independent physical therapists, and services related to End Stage Renal Disease (ESRD).

(See APPENDIX A for details regarding our sampling methodology, and APPENDIX B for the subsequent statistical projection of errors).

We determined that only 40 of the 100 sampled line items were reported on CHP's Medicare cost report and could have resulted in duplicate payments. We performed detailed review on these 40 line items and classified the remaining 60 line items as non-errors for our sample. We noted that of the 40 line items on which we performed detailed testing, CHP had notified providers of the potential duplication of payments in 14 cases via letter.

Condition

We determined that payments were being made through Medicare FFS to providers for services that were also reported by CHP in its annual cost report. In our sample of 100 line items, 18% of the line items represented services paid for by both Medicare FFS and CHP. Since Medicare reimbursed CHP for these same costs, Medicare has in effect paid twice, once directly and once indirectly, for the same services. We specifically identified $1,585 of such duplicate payments within these 18 sampled claims line items.

We also found no evidence of providers remitting refunds to Medicare in response to the CHP notice letters mentioned previously.

Cause

These overpayments occurred because: (1) CHP did not have an adequate mechanism in place to prevent duplicate payments; and (2) billing staffs of the physicians servicing CHP's enrollees were inadequately trained in the appropriate billing process.

CHP Payment Mechanism

CHP's provider contracts, which apply to both Medicare-eligible and non-Medicare enrollees, contain general language regarding the billing and payment procedures to be followed, such as "Only CHP is to be billed for services provided. The reimbursement will be accepted as payment in full, and the Member will not be held responsible for any portion of the fee…". However, no detailed billing process with respect to Medicare-eligible enrollees is specified in the contracts. In addition, CHP currently has no mechanism in place to ensure that providers are billing accurately under the contracts, such as a post-payment claims match of CHP payments with CMS payments for the same beneficiaries. Therefore, there is currently no mechanism, either embedded in CHP's claims payment system or prescribed in the operating procedures, to effectively prevent or identify duplicate payments.

Physician Billing Training

The issues with respect to training of physician staff to appropriately bill for claims are similar to those issues discussed below with respect to encounters.

Effect

The Medicare program paid twice for the same services rendered to enrollees of CHP. Projecting the findings from our review of 100 sample line items, we estimate that the Medicare program paid at least $23,573 in duplicate payments on behalf of CHP enrollees in 1999. We therefore request repayment of this amount. (See APPENDIX B for details on the sampling results).

Encounters

Due to the fewer number of *encounters* that could have potentially resulted in duplicate payments, we reviewed each of the 232 lines associated with encounters.

Condition

We determined that payments were being made through Medicare FFS for services that were also reported by CHP in its 1999 annual cost report. The CHP does not credit the cost report to show the correction of any double billing to Medicare by their providers. The CHP holds the provider responsible for the reimbursement and no further effort is made to ensure repayment.

Cause

These overpayments occurred because: (1) CHP did not have an adequate mechanism in place to prevent duplicate payments; and (2) billing staffs of the physicians servicing CHP's enrollees were inadequately trained in the appropriate billing process.

CHP Payment Mechanism

One area consistently mentioned by capitated providers as a cause for erroneous billing through Medicare was the inability to distinguish CHP enrollees from ordinary Medicare enrollees. Physicians are provided a printed list of CHP enrollees on a monthly basis. In addition, each CHP enrollee is given a CHP member card, but is *not* asked to relinquish their Medicare card. Unless a member voluntarily offers his CHP card when obtaining medical services, it is possible that the claims will be submitted directly to the physician's carrier for processing under Medicare fee-for-service. Physicians indicated that an electronic listing of CHP enrollees, provided either on a monthly basis or in real-time, would greatly assist in eliminating this problem.

Physician Billing Training

Discussions with providers revealed widespread confusion and unfamiliarity with appropriate billing procedures. Providers stated that CHP did not offer formal training for their staff on the billing procedures and requirements. The education level and turnover of billing staff were also mentioned by providers as an area of concern. CHP and Medicare (fee-for-service) were occasionally treated as primary and secondary payers rather than exclusive payers. The billing process is further complicated by the fact that, as a commercial HMO with retired enrollees, CHP could be billed along with Medicare in a primary/secondary role.

Effect

The Medicare program paid twice for the same services rendered to enrollees of CHP. The total number of encounters in the universe of 232 line items was 155. Of the 155 encounters relating to potential matches, 141 or 91% contained duplicate payments. The Medicare overpayment amount associated with these duplicate payments totaled $6,710.

RECOMMENDATION

We recommend that CHP refund the $30,283 in overpayments made on behalf of CHP enrollees. Specifically, we recommend that CHP file an amended cost report that:

- Refunds the $23,573 in estimated duplicate payments identified in this audit; and
- Records as credits, the $6,710 in duplicate payments that were made to physicians affiliated with and employed by CHP.

In addition, we recommend that CHP take steps to prevent duplicate payments from recurring in the future.

The CHP concurs with the OIG's recommendations and will contact CMS to further discuss these items. The full text of CHP's response is attached to this report as APPENDIX C.

APPENDICES

APPENDIX A

SAMPLING METHODOLOGY

OBJECTIVE:

The objective of this audit was to determine whether services that were claimed on CHP's 1999 Medicare cost report, and reimbursed by Medicare, were also billed to Medicare directly by providers and paid for under Medicare FFS, resulting in a duplicate payment for the same services.

POPULATION:

The population was the 6,991 line items that were identified as having the same date of service and Health Insurance Claim numbers (HICN) in Medicare FFS as CHP's paid claims database for the period January 1, 1999, through December 31, 1999. The line items totaled $714,409.

SAMPLE UNIT:

The sampling unit was a paid claim line item in the CHP database for 1999 that matched a Medicare fee-for-service payment.

SAMPLE DESIGN

A simple random sample was used.

SAMPLE SIZE:

We selected 100 line items from the universe that we identified.

ESTIMATION METHODOLOGY

Using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services RAT-STATS Variable Appraisal Program, we projected the erroneous payments to the universe of claims.

APPENDIX B

SAMPLE RESULTS AND PROJECTIONS

Sample Results

Sample Size	Number of Non-Zero Errors	Value of Errors
100	18	$1,585.15

Variable Projections

Point Estimate	$ 110,818
90% Confidence Interval	
Lower Limit	$23,573
Upper Limit	$198,062

Attributes Projection

We also used our random sample of 100 claims to project the percentage of claims in error. We used the Department of Health and Human Services, Office of Inspector General, RAT-STATS Attribute Appraisal Program to project the percentage of claims in error. The results of these projections are presented below:

Sample Claims in Error:	18
Point Estimate Percent:	18%
90% Confidence Interval	
Lower Limit Percent:	12%
Upper Limit Percent:	25%

Capital Health
PLAN

October 16, 2001

Mr. Chuck Curtis
Regional Inspector
General for Audit Services
US Dept. of Health & Human Services
Office of Inspector General
Office of Audit Services
61 Forsyth Street, SW Room 3T41
Atlanta, GA 30303

Ref: CIN A-04-01-01005

Dear Mr. Curtis:

This is in response to the draft report issued as a result of your review of Duplicate Medicare Fee-For-Service Payments at Capital Health Plan (CHP) for Calendar Year 1999.

OIG recommends that CHP:

1. Refund the estimated overpayment of $23,573 as identified in their sample.
2. Record as a credit, $6,710 in duplicate payments that were made to affiliated physicians.
3. Take steps to prevent duplicate payments from recurring in the future.

The appropriate management staff reviewed the draft report and CHP concurs with OIG's recommendations. CHP will contact CMS to further discuss the recommendations of your report. If you have any questions, please do not hesitate to contact me.

Sincerely,

Kearney W. Pool, CPA
Sr. Vice President, Finance and CFO

KWP/sw

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